Supreme Court, U.S.
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No.

In The

Supreme Court of the United States

October Term, 1996

PRISCILLA SAENZ, AS PERSONAL REPRESENTATIVE OF THE ESTATE OF CARMEN SAENZ, DECEASED,

Petitioner,

vs.

HUMANA HEALTH PLAN OF TEXAS, INC., DOING BUSINESS AS HUMANA HEALTH PLAN OF CORPUS CHRISTI AND HUMANA, INC.,

Respondents.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Federal Employees Health Benefits Act 5 U.S.C. §8901 et seq. and in particular 5 U.S.C. §8902(m)(1) provide that state laws which relate to coverage or benefits under contracts of health insurance issued pursuant to that act and the program it created are preempted to the extent that they are inconsistent with plan provisions. The question is whether or not approximately 12,000,000 Americans, roughly 3,000,000 federal employees and their potential dependents are deprived of any right of action for abusive and deceptive practices by health insurance carriers no matter the degree of the same and no matter how devastating the effect on the grounds that state laws which create implied covenants of good faith and fair dealing and so forth are preempted in turn on the grounds that such an obligation is somehow inconsistent with the obligations of insurers under the health insurance policy/plan they sell to federal employees?

PARTIES

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PETITION FOR WRIT OF CERTIORARI

The petitioner, Priscilla Saenz, as personal representative of the estate of Carmen Saenz, respectfully requests a writ of certiorari to permit her appeal from the adverse decision of the Fifth Circuit Court of Appeals to the effect that in spite of numerous deceptions, abusive practices, and other unjustified indecent conduct on the part of her insurer, Humana Health Plan of Texas, Inc. et al. all state laws creating causes of action for such things are preempted on the grounds that such laws are inconsistent with provisions of the insurance policy sold by Humana and are inconsistent with Humana's obligations to the insureds as a participant in the Federal Employees Health Benefits Program. See, *Vail vs. Texas Farm Bureau Mutual Insurance Company* 754 S.W.2d 129 (Tex. 1988), *National Union Fire Insurance Co. vs. Dominguez*, 873 S.W. 2d 373 (Tex. 1994) and *Burkey vs. Government Employees Hospital Association*, 983 F.2d 656 (5th Cir. 1993).

OPINIONS BELOW

The January 7, 1996 order and opinion of the Federal District Court for the Southern District of Texas, Corpus Christi Division is unreported and is reproduced in the appendix to this petition, p. 12-15.The subsequent opinion of the United Court of Appeals for the Fifth Circuit No. 96-4011 *Saenz vs. Humana*, unpublished, is reproduced in Pet. App. 1-9 in its entirety. The Fifth Circuit's order denying the petitioner for rehearing of January 10, 1997 is reproduced in Pet. App.

JURISDICTION

The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §1254 (1) and particularly because there is a conflict in the opinions of various federal appellate courts on issues raised here and because this petition raises substantial questions concerning health insurance and its administration for approximately 3,000,000 federal employees and their dependants. This is an appeal from the Fifth Circuit Court of Appeals and their ruling dated December 12, 1996 and their order denying a petition for rehearing dated January 10, 1997.

Federal jurisdiction was probable for the district court and court of appeals because the plaintiff did not object to what may have been improper removal. The plaintiff subsequently amended her complaint to include a federal claim and thereafter receives a trial on the merits which included a summary judgment disposition. *Kidd vs. Southwest Airlines Co.*, 891 F.2d 540, 545-547 (5th Cir. 1990) (The foregoing statement concerning jurisdiction is taken from the court of appeals' decision in this case. *Saenz, **supra,*** Pet. App. p. 3.

STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED

This case involves the Federal Employees Health Benefits Act 5 U.S.C. §8901 et seq. and in particular 5 U.S.C. §8902(m)(1) which states as follows:

> The provisions of any contract under this Chapter which relate to the nature or extent of coverage or benefits (including payments with the

respect to benefits) shall supersede and preempt any state or local law, or regulation issued thereunder, to the extent that such law or regulation is inconsistent with such contractual provisions.

STATEMENT OF THE CASE

Carmen Saenz was a federal employee residing in Corpus Christi, Texas working on the staff of Congressman Solomon Ortiz of the 24th Congressional District of the state of Texas. In 1986 she acquired a health plan through Humana Health Plans of Texas, Inc. pursuant to the Federal Employees Health Benefits Act. She renewed thereafter each year until her death.

In the fall of 1992, she was diagnosed with a fatal form of cancer of the bone. She was referred for treatment to the University of Texas Medical Branch – M.D. Anderson Cancer Care Center in Houston, Texas. Over the first six months of 1993 a variety of treatments were administered. In the summer of 1993, a treatment protocol was submitted by M.D. Anderson to Humana for approval in advance. The treatment called for the administration of a drug known as Ifosfamide in a dosage described as 14 grams per meter squared times four.

The medical director for Humana refused to approve payment for that treatment, if administered at M.D. Anderson, on the grounds that the same treatment could be provided in the Corpus Christi area through oncologists practicing under contracts between themselves and Humana.

Carmen Saenz contested Humana's refusal to pay and simultaneously proceeded to obtain the treatment at M.D. Anderson. She appealed to Humana and her appeal was denied. She subsequently filed an appeal to the Office of Personnel Management pursuant to FEHBA and the health plan.

During the summer of 1994, after the appeal had been pending before the Office of Personnel Management for approximately five months, with no action on their part, Carmen Saenz discovered that the dosage level was considered extremely high dose chemotherapy which in turn could only be administered safely, relatively speaking in a cancer care specialized center such as M.D. Anderson.

Approximately one year after initially denying the claim, Humana convened a "grievance committee". The grievance committee conducted a hearing of a sort and Humana reversed itself. M.D. Anderson was paid at some point thereafter.

This case was commenced before a state district court and removed to federal court on federal question jurisdiction in connection with FEHBA. The district court ordered the petitioner to amend and plead every cause of action the petitioner considered to be available to her.

The claims pled were violations of the Texas law of good faith and fair dealing, fraud in the inducement, fraud, violations of the Deceptive Trade Practices Act, violations of the Texas Insurance Code, etc. In the amended complaint which is item 27 in the Record of Proceedings before the District Court, there is an extensive description of the acts and practices conducted by

Humana with regard to administration of its insurance program generally and with regard to Carmen Saenz in particular. The facts pled include but were not limited to the following and are recited by paraphrasing from the Petitioner's Amended Complaint:

1) Humana represented that it would provide the best of health care through its advertising, when in fact its local executive director stated that Humana's goal was only to provide high quality care and not the best of medical care.

2) Humana's medical director admitted lying to Carmen Saenz in a letter describing the process he had undertaken to investigate whether or not the treatment protocol described above could be safely performed in Corpus Christi as compared to M.D. Anderson.

3) Humana has a practice of providing quotas to its primary care physicians in terms of a fixed number days of hospitalization per year per thousand patients and a fixed dollar amount for the cost of referrals to specialists. If either of those were exceeded the primary care physicians were deprived of bonuses which make up to 40% of their income. Humana therefore provides a direct financial incentive to its primary care physicians not to hospitalize patients and not to refer patients to specialists.

4) Humana has a practice of insisting that its primary care physicians, general practitioners or family practitioners, supervise the care of critically ill people in particular cancer patients when such physicians are not qualified to do so. Humana has expressly stated that its primary

care physician should "quarterback" the treatment plans of oncologists for cancer patients.

5) Humana refused to cooperate with Mrs. Saenz' investigation with refusing to disclose the name or names of the physicians who supposedly had opined that the Ifosfamide treatment could be done in Corpus Christi.

6) Humana's profit motive was so overwhelming that after suffering a pathological fracture of her hip and being hospitalized in a surgical ward of a local hospital, Carmen Saenz was moved by ambulance to a nursing home for several days and then back at a point in time when the surgery could be performed in the same hospital she had originally entered. At the same time there was a skilled nursing center on the same floor that Mrs. Saenz was originally hospitalized in approximately seventy-five feet away from her original hospital room. Nonetheless, Humana put her through the misery of being hauled around Corpus Christi and in and out of the two facilities to save the spread between the nursing home's charges per night and the hospital's daily room rate for a period of three or four days.

Numerous other examples of conduct that would violate any standard of human decency and beyond that the Texas law of good faith and fair dealing are recited in the amended complaint. With regard to Humana's general business practices, Carmen Saenz alleged that she would not have purchased a policy from them or would not have continued to renew had she known the true state of affairs before their methods became apparent in the fall of 1993 and thereafter.

After the amended petition was filed, Humana filed a motion for summary judgment and a motion to dismiss for failure to state a claim upon which relief may be granted. Those motions were granted on January 7, 1996 by the district court on the grounds that all of the claims stated by the petitioner were preempted with the exception of the petitioner's RICO claim which the Court also denied. On appeal before the Fifth Circuit, the petitioner did not pursue the RICO claim.

REASONS FOR GRANTING THE WRIT

The full text of the main complaint from which the above discussion of the facts is extracted is located in the proceedings of the district court at item 27. In the argument section references made to the health insurance plan/policy. The full text of the plan/policy is set out in the proceedings of the district court at item 33 App. A ex. A8. Also in the argument are references to a contract between the Office of Personnel Management and Humana Health Plan of Texas, Inc. All versions of the contract from 1987 through 1993 are in the record of the district court. The 1993 version is located at item 33 App. A ex. A7.

The preemption provision of the Federal Employees Health Benefits Act 5 U.S.C. §8901 et seq. states that only those state laws that are inconsistent with some provision within the insurance policy are preempted even though they may relate to coverage and benefits. The wide variety of abusive acts and practices on the part of Humana which are described in the pleadings before the district court must be taken as true since this case was decided

on the basis of the pleadings. All of the acts and practices alleged before the district court would be actionable under one law of Texas or another.

Under the rulings of the Fifth Circuit as announced in *Burkey vs. Government Employees Hospital Association* 983 F.2d 656 (5th Cir. 1993) and in this case *Saenz vs. Humana Health Plan of Texas, et al.* No. 96-40111 (5th Cir. 1996) opinion ordered unpublished the petitioner and all others like her have no remedy no matter how grievous and malicious the conduct of their insurers and no matter how devastating the impact upon them save and except to pursue an administrative claim before the Office of Personnel Management. That claim being limited to relief in the form of a ruling that the benefits should be paid or not paid without more and failing success before O.P.M., the insured has a right of appeal to the district court but only to seek to prove that the action of the Office of Personnel Management was arbitrary and capricious.

This case has the potential to affect the health insurance and health care of approximately 3,000,000 federal employees and their dependants.

There is a conflict between the Fifth Circuit as announced in *Burkey, **supra,*** and the Tenth Circuit's opinion in *Howard vs. Group Hospital Service,* 739 F.2d 1508 (10th Cir. 1984); which holds that not all state law claims are preempted.

Because the opinion of the Fifth Circuit in this case and others conflicts with opinions of this Court as to statutory interpretation, because there is a conflict in the opinions of the United States Courts of Appeals and because the law of this case potentially affects up to

12,000,000 Americans, the petitioner respectfully submits this petition and prays that the same be granted.

ARGUMENT

This is a case of statutory interpretation. The statute is as follows:

> The provisions of any contract under this Chapter which relate to the nature or extent of coverage or benefits (including payments with the respect to benefits) shall supersede and preempt any state or local law, or regulation issued thereunder, to the extent that such law or regulation is inconsistent with such contractual provisions. (5 U.S.C. §8902(m)(1)).

This Court recently announced the procedure for statutory interpretation. *Robinson vs. Shell Oil Company* 117 S.Ct. 843 (1997). The procedure is to determine whether the statute has a plain and unambiguous meaning with regard to the particular dispute in case. If the statutory language is unambiguous and the statutory scheme is coherent and consistent the inquiry ends. The existence of an ambiguity is determined from the statutory language itself, the specific context in which that language is or was used and the broader context of the statute as a whole.

This statute simply says that state law, etc. is preempted to the extent that it is inconsistent with any provision in an insurance policy issued under the Federal Employees Health Benefits Act, 5 U.S.C. §8901 et seq. The inquiry mandated by this Court is whether or not the

state statutes and/or common-law causes of action asserted by the petitioner are inconsistent with some provision in the insurance policy sold to Carmen Saenz by Humana.

The causes of action she asserts are as follow: 1) An implied covenant of good faith and fair dealing as defined under Texas law and *Vail vs. Texas Farm Bureau Mutual Ins. Company* 754 S.W. 2d 129, 137 (Tex. 1988).; 2) common-law fraud in the inducement; 3) the Deceptive Trade Practices Act and its subdivisions, V.A.T.C.S. Bus. and Com. Code §17.41 et seq. and; 4) various provisions of the insurance code of the state of Texas which are in part the statutory equivalent of the implied covenant of good faith and fair dealing and which would elaborate on the duties of insurers to insureds with regard to claims handling, sales and so forth. V.A.T.C.S. Ins. Code art. §21.21 et seq.

It comes as no surprise that the insurance policy contains no provision that states or implies that bad faith and unfair dealing are permitted. Likewise, there is no provision in the policy to the effect that the insurer has the right to deceive the insured in order to get the insured to buy the policy. Further, there is no provision that says that the insurer may misrepresent the scope of coverage or benefits, to get the insured to buy the policy. As a corollary, there is no provision that says that it is permissible for the insurer to fail to disclose material information concerning the policy. Those concepts all of course relate to the Texas Deceptive Trade Practices Act. §17.46b et seq. Finally there is nothing in the policy that says that insurers do not have to investigate claims fairly and promptly, communicate with the insured, release

information to the insured about the claim, and so forth. Considering this Court's ruling in *Robinson, **supra,*** the above discussion would seem sufficient to settle the question in favor of the petitioner's argument.

However, there is an even stronger argument in that policy does in fact mandate in several instances fairness, honesty, promptness, and so forth with the penalty for failure to comply not being limited merely to simple relief in the form of a monetary judgment, but going so far as to cite the potential for imprisonment.

The policy contains the following provision:

> "Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain benefits or in order to increase the amount of FEHBA benefits, is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider such as a doctor, hospital, pharmacy, etc., charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information take the following actions:"

Simply put, that provision means that anyone who deceives the insurance company is subject to loss of benefits, loss of money, and loss of freedom at least in theory. Put another way, if a prospective insured makes a misrepresentation on an application in order to get insurance. this provision clearly authorizes the insurer to set aside the policy, seek civil relief, and if it chooses to pursue criminal prosecution based on fraudulent inducement by

the insured. It is impossible logically or legally to argue that if fraudulent inducement on the part of the insured may subject him to imprisonment under the terms of the policy, there is an inconsistency considering that policy as a whole with a right to pursue a mere civil claim for fraudulent inducement by the insured.

The age-old metaphor, "what is good for the goose is good for the gander", is instructive. Put another way, courts have confronted, in diverse settings, the "age-old problem" of "(P)roviding equal justice for poor and rich, weak and powerful alike". *M.L.B. vs. S.L.J.*, 117 S.Ct. 555 (1996) p. 560. Quoting *Griffin vs. Illinois*, 351 U.S. 12, 16, 76 S.Ct. 585, 589, 100 L.Ed. 891 (1956). It is difficult to conceive statutory language that is more clear than the "inconsistency" clause at 5 U.S.C. §8901 (m). It is equally difficult to conceive of any greater disparity than that between a major national health insurer and a terminally ill cancer patient who was a one time congressional staff member considering that the insurer has the potential power to imprison the cancer patient for deception and the cancer patient on the other hand is legally helpless when deceived by the insurer.

If the policy demands honesty and fair dealing from the insured it is contrary to the technical approach to statutory interpretation discussed above and contrary to the fundamental concept of justice described in *M.L.B. vs. S.L.J.*, ***supra,*** to say that the laws requiring the same degree of conduct from the insurer as from the insured are inconsistent.

The plan/policy also states, "because the plan both provides your care then pays the cost, it will seek sufficient and effective delivery of health care services. By controlling the necessary or appropriate care, it can afford to offer a comprehensive range of benefits" (District Court proceedings item 33 App. A ex. A8 p. 6) There is obviously nothing in that provision that suggests anything other than that the insurer provide effective care and appropriate care. There is certainly nothing in that language that suggests that the insurer has the right to seek the cheapest possible treatment facility, medical practitioner, or course of therapy.

At the heart of the Texas law of bad faith and unfair dealing is the requirement that an insurer may not delay payment or deny claims without reasonable justification. *National Union Fire Insurance Co. vs. Dominguez,* 873 S.W. 2d 373 (Tex. 1994). The plan does contain a reference to punctuality concerning claims. At page seven the plan states that when an insured is required to submit a claim to this plan for covered expenses the claim should be submitted promptly. If the plan mandates that the insured is to act promptly it is certainly an indication in that context that promptness can be expected of the insurer. While that provision does not speak to the insurer's obligations, it certainly is not an indication that unjustified delay in payment or denial of claims is acceptable.

Also on page seven the plan states: "plan providers will follow generally accepted medical practice in prescribing any course of treatment". If anything, that language supports the idea that the insurer will not

indiscriminately and unjustifiably deny claims or refuse to preapprove generally accepted medical treatments.

At page eight in the plan it states that no oral statement of any person can modify or otherwise affect the plan. One aspect of that provision is that no statement by a doctor, utilization review nurse, or sales agent which contradicted the express provisions of the plan concerning benefits, etc. could be used to modify the plan. Put another way, the plan insists that coverages and benefits are tied to the express provisions of the plan. If the insurer insists that it cannot legally be compelled to pay for benefits which are not provided for under the plan, is it not equally fair that the insured has a right of action where benefits are unjustifiably delayed or unjustifiably denied?

If, for example, a given treatment is considered generally accepted medical practice such as high dose chemotherapy for stage III breast cancer patients, should an insurance company be permitted to arbitrarily deny such a claim on the grounds that the treatment was experimental solely based on the oral opinion of a physician who's identity was not disclosed to anyone. For a general discussion of such a problem involving breast cancer see *Henderson vs. Bodine*, 70 F.3d 958 (8th Cir. 1995). To illustrate, assume that the medical director of the insurance company ignored a vast body of medical and legal authority to the effect that high dose chemotherapy is a generally accepted medical treatment and shopped various consulting companies and obscure oncologists until he found one, willing for a price, to opine that such treatments are experimental. If an oral statement by an employee of the insurer or a doctor practicing under a

contract with the insurer cannot modify the insurer's coverage under the plan or as a corollary cannot create some right in favor of the insurer/patient, how can it be said that the insurer is justified in deviating from the ordinary meaning of generally accepted medical practice on an arbitrary and capricious basis on the grounds of a unsubstantiated oral opinion. The point is that if the insured is bound to the terms of the policy it is not inconsistent in light of the above provision to hold the insurer to the same standard.

On page eight of the plan there is a provision to the effect that the insured must disclose to the insurer any other sources of benefits. Obviously, the insured is put to a good faith duty not to double dip. That is another example of policy implications that the insured is expected to conduct himself or herself in good faith. If that is expected of the insured how can it be said that anything less is expected of the insurer.

The only plan provisions that could conceivably be considered inconsistent with the Texas state law of bad faith and unfair dealing are located on page 18 in the sixth and seventh paragraphs. Paragraph six commences with the statement that no lawsuit may be brought to recover on a claim for plan benefits until an administrative review through the Office of Personnel Management has been completed. The key phrase is on a "claim for plan benefits . . . ". The foundation of any bad faith case is proof that the benefit sought was in fact provided under the contract of insurance. On page 18, paragraph six and seven establish how the insured must proceed to establish that she is entitled to benefits under the plan.

An element of any bad faith claim is to establish that the benefits sought were in fact provided under the plan. Sometimes that issue remains disputed throughout. Sometimes the insurer concedes that the benefits should have been provided. When that happens, the only issue being debated is the reasonableness or lack thereof of the insurer's delayed acknowledgment that benefits were due under the plan itself. To illustrate, obviously, where a given claim is not allowed by a plan, an insurer would inherently be justified in not paying. Paragraph six by its own terms is expressly limited to claims for plan benefits and nothing more. Paragraph seven states "Federal law exclusively governs" all claims for relief in a lawsuit that relates to plan benefits for coverages or payments with respect to those benefits. Paragraph seven continues that judicial action on such claims for relief is limited to a review of the Office of Personnel Management's final decision to determine if it is arbitrary or capricious. Page 18 taken in its entirety and the statutory language of FEBHA, 5 U.S.C. §8901 et seq., taken all together authorize the Office of Personnel Management only to examine the coverage questions in terms of what is and what is not provided under a given plan. That is nothing more or less than the purely contractual question that arises under all bad faith claims in that the first step on the part of the insured is to prove that there is in fact coverage for a loss, where the insurer continues to dispute the question.

Rather than being inconsistent with a claim that benefits were denied without justification, the contents of

page 18 in paragraphs six and seven provide the mechanism for solving the first legal problem by an insured under the law of bad faith and unfair dealing.

Since the only thing the Office of Personnel Management is entitled to review is a denial of claims in terms of a simple yes or no fashion, the language in paragraph seven " . . . all claims for relief in a lawsuit . . . " could only refer to simple coverage questions since that is all that the Office of Personnel Management can consider at the administrative level. When the phrase "all claims for relief" as used in paragraph seven is defined by what the Office of Personnel Management can consider at the administrative level, then it becomes clear that the phrase "federal law exclusively governs" refers to those laws of federal procedure and contractual interpretation that would apply to such matters.

The point is that there is nothing inconsistent with the fact, as described on page 18, that the denial of benefits will be reviewed by the Office of Personnel Management and a duty of the insurer to act in good faith. Where there is a finding by the Office of Personnel Management that claims are covered, the insured may also have a parallel claim under state law through which the insured can call into question the insured's conduct by way of whether or not there was any justification for the denial or delay in making payment.

Under Texas law there is precisely the sort of parallel approach available to state employees as is described above. A state employee with a complaint about insurance has administrative remedy through the Employee Retirement system. That state agency has jurisdiction

only to consider whether or not there is coverage. Any "extra contractual claims" are not within the agency's jurisdiction. However, the state employee is entitled to assert those claims, assuming coverage issues are settled in the employees favor, in state courts. There is no requirement to bring those claims, such as bad faith, deceptive trade, insurance code violations, and so forth to the attention of the state agency since it has no jurisdiction. *Montgomery vs. Blue Cross & Blue Shield,* 923 S.W. 2d 147 (Tex. App. – Austin, 1996) pp. 151-152.

The last step in statutory analysis is to attempt to discern congressional intent from a combination of the language, the overall statutory scheme, and the context in which the statute was enacted. The only realistic way to measure the legal result of a given interpretation is to consider that result in the light of whether or not Congress could possibly have intended such a thing. *Robinson, **supra,*** 846. To date, the rulings of the lower courts, with one exception, have been that every state court cause of action brought to their attention in a FEHBA case has been preempted. *Howard vs. Group Hospital, **supra*** and *Burkey vs. GEHA, **supra*** citing others. Since there are no parallel federal statutes with regard to good faith and fair dealing, etc., the insureds are, according to the various appellate courts, left without remedy. Those courts deem such things to be matters of policy choices by Congress. *Saenz, **supra,*** Pet. App. at 8.

To put things bluntly, according to the present prevailing "interpretations", insurers selling health policies to federal employees and their dependents are completely free to use any sales tactic they choose no matter

how fraudulent; to deny claims no matter how maliciously and no matter how devastating the impact on the insured; and to manipulate claims handling in any form or fashion they wish knowing that in the face of that type of conduct the insured has only an administrative remedy by way of an appeal to the Office of Personnel Management in which he can only seek to recover benefits which should have been provided, but without a provision entitling him to attorney's fees and under circumstances where if unsuccessful before O.P.M., the insured must proceed to Federal Court solely with the hope that O.P.M. will be deemed to have acted arbitrarily and capriciously. The insured, so says Congress according to the appellate courts, must attempt to accomplish all of that without even being able to make a claim for attorney's fees for representation. That is the result which the Fifth Circuit and other appellate courts announce as being the intent of Congress as a matter of a policy choice. *Burkey, **supra,*** and *Saenz, **supra.*** Whatever the courts may say about the role of O.P.M., it is undeniable that the only remedy a federal employee has is to seek a determination of the single issue before O.P.M., which is the question of coverage, and nothing more save and except interest and court costs if he is forced to proceed to litigate and is successful.

The points raised here were never given fair consideration by the Fifth Circuit Court of Appeals in what has become the lead case, *Burkey vs. Government Employees Hosp. Ass'n,* 983 F.2d 656 (5th Cir. 1993). In *Burkey,* the Court considered only the "relates to coverage" language of 5 U.S.C. §8902(m)(1) and there is no mention in the

opinion of the operation or affect of the "inconsistent with" language.

*Burkey, **supra,*** p. 666. The operative phrase from *Burkey* is that the imposition of state law claims would "invariably expand GEHA's obligations." *Burkey* dealt with a Louisiana statute on good faith and fair dealing. The Fifth Circuit noted that that statute was similar to the Texas law of good faith and fair dealing as announced in *National Union Fire Insurance Company, supra.*

In both cases the Fifth Circuit ruled that state laws requiring insurance companies to pay claims promptly, absent reasonable justification, and to refrain from denying claims without justification *expanded* insurer's obligations under the two plans at issue. (Underlining ours). *Burkey, **supra,*** p. 666, *Saenz vs. Humana Health Plans of Texas, Inc. et al.* No. 96-40111 (5th Cir. 1996) (opinion ordered unpublished), p. 5. It is self evident that state laws requiring prompt payment of claims absent justified delay and prohibiting unjustified denials could only expand the obligations of insurers under FEHBA if there is no such preexisting obligation at all. Exactly that point was made both in the appellant's brief and during oral argument before the Fifth Circuit. Nonetheless, the Fifth Circuit dismissed that point by stating that as *Burkey* points out a covenant of good faith and fair dealing as defined in Texas would invariably expand insurer's obligations. The Fifth Circuit ignored the fact that the *Burkey* opinion never considered the "inconsistent with" language. Oddly enough, nowhere in *Burkey* is there any discussion of what the insurer's obligations are or are not concerning good faith and fair dealing under FEHBA.

The Fifth Circuit did reiterate the district court's comments about a lack of human decency on the insurer's part. *Burkey,* 983 F.2d p. 661.)

The Fifth Circuit then suggested that, absent preemption, the application of state remedies would "foster interstate conflicts" in plan administration. *Burkey,* 983 F.2d p. 660. Ironically enough, the Court immediately thereafter pointed out that the Louisiana statute at issue in *Burkey* and the Texas Common-Law cause of action at issue here are "similar". *Burkey,* 983 F.2d p. 660. There is an anomaly in suggesting that state laws create conflicts among themselves from one state to the next when simultaneously pointing out that the two state laws at hand are similar. Above and beyond that is the proposition that the state common-law of fraudulent inducement, fraud, and good faith and fair dealing are extremely similar if not virtually identical as to the elements of each cause of action from one state to the next.

In this particular instance, the theory of invariable conflict among state laws cannot possibly hold true because the plan expressly states on its first page that in order to enroll prospective insureds must live in one of four contiguous counties in South Texas surrounding Corpus Christi. It is therefore literally impossible for the relationship between any participant and Humana under this plan to be affected by the law of Louisiana or any other state, save and except Texas.

As an aside, the petitioner takes no issue with the proposition that since the Office of Personnel Management has the power to order the inclusion of certain treatments, benefits, and coverages that companion state

laws to the same effect could in fact create potential conflicts in coverages. For example, Texas law prohibits the inclusion of any provision in a group plan adversely affecting treatment for Acquired Immune Deficiency Syndrome. V.A.T.C.S. Ins. Code 3.51-5A(a)(1) The petitioner does not argue that the states should not be permitted to prescribe specific benefits or specific exclusions for plan sold under FEHBA.

At the same time suppose that an A.I.D.S. patient's claims were unjustifiably denied by the insurance company or by his insurer because the same hoped that he would not have sufficient resources physically, mentally or financially to pursue claims before he died.

As gruesome and malicious as such a scenario is, the Fifth Circuit would answer that the insured/patient had no remedy for such conduct because such conduct is not prohibited under FEHBA and under the policy of insurance. That Court would contend that that is a result of Congress's policy choice. If this Court is inclined to soothe itself by saying that such a scenario occurs only in the imaginations of lawyers such as petitioner's counsel, the Court is respectfully referred to the Fifth Circuit's opinion in *Corcoran vs. United Health Care, Inc.*, 965 F.2d 1321 (5th Cir. 1992) p. 1337-1339. Although an ERISA case, it dealt with facts describing conduct by an insurer that was nothing short of malicious. It is not in the least reassuring to know that had Mrs. Corcoran been a federal employee insured under a plan issued through FEHBA, her baby would be just as dead. To put the question to the ultimate test it is impossible to imagine any congressman standing before his constituents, whether members of the judiciary were present or not, and announce that it was

his policy choice that insurance companies selling insurance to federal employees be free to be as abusive as they wish subject only to the employees' administrative claim for benefits which should have been paid and nothing more save interest and court costs no matter how offensive and destructive the conduct of the insurer. See also *Burkey,* p. 661 quoting the district court.

The Fifth Circuit takes great comfort in the idea that the insurers are subject to contracts with the Office of Personnel Management. *Saenz,* p. 6 & 7. However, the only remedy available to O.P.M. no matter what the insurers choose to do, assuming O.P.M. ever finds out about it, is to refuse to renew the contracts authorizing a given insurer to sell to federal employees. To say that that is a sufficient remedy is somewhat like saying that a sailor who sells military secrets to the Russians is sufficiently punished by being kicked out of the Navy. Under either scenario the offender gets to keep his profits.

Beyond that, the Fifth Circuit says nothing about the underlying rationale behind the implied covenants of good faith and fair dealing as adopted by the various states; which is that merely making insurance companies pay claims, plus attorney's fees and interest after an insurer has unjustifiably denied a claim is not a sufficient protection for the public. As Texas Courts have stated, merely making the insurers do that which they should have done without argument in the first place is not a sufficient deterrent to dissuade them in the future. *Vail vs. Texas Farm Bureau and Mutual Insurance Company,* 754 S.W. 2d 129 (Tex. 1988) p. 136-137.

With regard to fraudulent inducement claims, the Fifth Circuit in its opinion in this case seems to take comfort in the idea that O.P.M. must approve all materials used by insurance companies to solicit customers. *Saenz, **supra.*** In essence, the Fifth Circuit appears to mean that since O.P.M. reviews the advertising materials, everyone involved can be adequately assured that the insurers will all conduct themselves in a matter consistent with their advertisements. The Fifth Circuit seems to suggest that somehow O.P.M. can discern from *Humana*'s advertising whether or not *Humana* will act in a manner consistently with its ads. To illustrate, the petitioner concedes that if *Humana* advertised that purchasing its policies would prevent cancer, someone reviewing such an ad at O.P.M. might be alerted. However, when, as the petitioner alleges here, *Humana* advertises that it will provide the best of care, the only way for O.P.M. to ascertain whether or not such is the case would be to conduct some sort of an audit. Neither FEHBA nor the contract between Humana and O.P.M. make any such provision for that kind of "audit".

With regard to Congress's intent, compared to the results in the opinions discussed above, consideration of other statutes relatively similar to FEHBA is instructive. FEHBA, Civil Rights Act of 1964, and the Americans with Disabilities Act, are all basically federal statutory programs designed to enhance the lives and provide expanded civil liberties and benefits to individuals.

The Americans with Disabilities Act, 42 U.S.C. §12101 et seq. contains widespread mandates benefitting disabled persons in a variety of contexts. Under those

statutes, a party who makes it too difficult for a wheelchair user to enter a building is subject to actual damages, interest, attorney's fees, and even punitive damages.

Under the Civil Rights Act of 1964, 29 U.S.C. §1001 et seq. it is unlawful to refuse food service, public accommodations and employment, among other things, to a citizen on the basis of his race, creed, etc. A violator of that Act is subject to a judgment which could include actual damages, interest, attorney's fees, costs of court, and punitive damages.

Can it possibly be said that if Congress intended to provide that level of protection to Humana's own employees be they disabled, minorities, or a member of any other protected class; at the same time Congress did not intend to protect Humana's insureds from the kinds of practices described in the pleadings before the District Court. If a secretary in Humana's office was legally entitled to recover actual damages and punitive damages for mental anguish caused by a sexually offensive gesture, does it stand to reason that Humana's insureds are without remedy, in the eyes of Congress, if Humana refuses to pay for cancer care when it undeniably should in spite of the devastating, emotional impact such a denial may have; to say nothing of the possibility that the patient may be unable to get potentially life-saving treatment because of the conduct of the insurer.

Another similar statute is the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1009. In *Varity Corp. vs. Howe*, 116 S.Ct. 1065 (1996), this Court, in interpreting the language of that statute, found that a fiduciary duty existed between benefit administrators and

beneficiaries. Under that duty fraudulent statements, oral or otherwise, were deemed to be actionable by the beneficiaries.

To the extent that *Varity Corp.*, ***supra,*** reflects this Court's interpretation of congressional intent and this Court has found that Congress intended that the fiduciary applies under ERISA, it is impossible to argue that this Court could find that no companion duty exists between health insurers and federal employees/beneficiaries under FEHBA as a matter of congressional intent. It cannot be logically argued that Congress intended so much less protection for its own fellow federal employees and at the same time so much more protection for private sector employees relative to their employers and insurers.

The Fifth Circuit in its opinion in this case below, see *Saenz vs. Humana,* ***supra,*** p. 7 reaffirms the wisdom of its own rulings by describing the "protective shield" it envisions the Office of Personnel Management as providing for federal employees relative to their insurers. That comment is painfully circular and self-serving. Under the present state of the law as created by the Fifth Circuit, virtually all claims such as this, if not discouraged completely, are extinguished at the pleadings stage based on motions for summary judgment, all of which invariably cite *Burkey* as leading authority. In effect, when preemption is applied by the Fifth Circuit, the extent of the damage done by the Fifth Circuit's opinions in *Corcoran,* ***supra,*** and *Burkey,* ***supra,*** will never be known unless this Court intervenes because the preemption concept as applied in those cases simultaneously cuts off the legs of legitimate claims and covers the ears and eyes of the Courts.

Throughout the opinions on FEHBA and preemption there appears to be an unspoken theme involving cost control. The Court's reference in *Burkey, **supra,*** to invariably expanding insurance obligations seems to be at least a hint of that. However, under the Texas law of good faith and fair dealing as announced in *National Union Fire Insurance Co. vs. Dominguez,* 873 S.W. 2d 373 (Tex. 1994), the insured is put to the burden of proving that there were no justifiable grounds for denying a claim or delaying payment. Application of a Texas claim for bad faith and unfair dealing under that rule could only expand an insurer's obligation if the Court felt the effective cost control included allowing insurers to escape paying claims they should in fact pay. In other words, the current Texas law of good faith and fair dealing could not possibly modify the scope of coverage because it deals with denials or delays of valid claims.

A court or other entity antagonistic to the petitioner's position might point out that although under this approach Texas law would not expand the obligations of insurers, it would allow additional damages and remedies for violations of those obligations. That approach if taken to its extreme means that insurance companies are more in need of protection from bad faith claims, etc., by their cancer patient insureds then the cancer patient's need protection from their insurance companies.

To put things in a bit different perspective, if the level of what amounts to bad faith activity is high as the pleadings in this case might suggest, then there is great need to provide protection to the insureds. If as the insurance industry would insist, the incidence of bad

faith conduct is almost non-existent, then assuming they are correct, the financial impact from allowing state claims would be insignificant because so few claims would be presented. The only qualification to that would be if the insurance industry argued that there were large numbers of federal employees who, with the help of their attorneys, would knowingly file frivolous claims thereby unfairly and unjustifiably increasing the expense to a level that could be a cost control concern. With an apology for being sarcastic with regard to the insurance industry, the petitioner would suggest that relatively few federal employees have enough spare time to plan heart disease or contracting cancer in order to have a golden opportunity to bring a frivolous lawsuit against their health insurer. Some elements of our society are amazed and disgusted at the lengths some plaintiffs will go to develop a frivolous basis for litigation, however, to date there are no reported decisions of any plaintiffs, federal employees, or otherwise, deliberately developing cancer in order to get a chance to stick it to their insurance companies when they improperly refuse to pay for treatment.

To conclude by returning to the point in the beginning, this Court announced in *Walters vs. Metropolitan Educational Enterprises, Inc.*, 117 S.Ct. 660 (1997) that words in a statute are assumed to bear their ordinary contemporary common meaning and that statutes must be interpreted, if possible, to give each word some operative effect. Save and except the unpublished opinion in this case, no federal appellate court has considered to what extent state laws such as those mandating good

faith and fair dealing are or could be somehow inconsistent with the language of an insurance policy, with the language of FEHBA, or with common sense ideas concerning the duties of insurers to insureds. Congress's policy choice concerning the extent of preemption was clearly that preemption be at least something less than complete. If it meant otherwise, Congress clearly would not have used the "inconsistent with" clause. To give meaning to that clause, it must be that at least some state claims are not preempted. If it is fine with Congress for insurance companies to lie to federal employees to get them to buy insurance policies, then a fraud in the inducement claim is inconsistent with the program. If it is Congress's policy that insurance companies be free to deny claims and/or to delay paying claims without reason, then there would be an inconsistency. If such things are not acceptable under this program, then the state law claims are not inconsistent with the program or with the language of any particular policy.

Carmen Saenz knew she would not live long enough to see this case resolved during her life. Her religious faith was such that she believed that there would be a life after this and that she would know the outcome. During her life, she prayed that her claim would succeed. The petitioner respectfully prays that this Court would so hold and the petitioner hopes that Carmen was right in her faith that although we cannot see her that she can see us.

CONCLUSION

For the foregoing reasons and based on the authorities and arguments recited hereinabove, the petitioner respectfully prays that, a writ of certiorari should issue to review the decision of the Fifth Circuit Court of Appeals.

Respectfully submitted,

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UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 96-40111

PRISCILLA SAENZ, As Personal Representative of the Estate of Carmen Saenz, Deceased

Plaintiff-Appellant,

versus

HUMANA HEALTH PLANS OF TEXAS, INC., Doing Business as Humana Health Plan of Corpus Christi and Humana, Inc.

Defendants-Appellees.

Appeal from the United States District Court
for the Southern District of Texas
Corpus Christi Division
(CA-C-95-17)

(Filed Dec. 12, 1996)

Before JOLLY, JONES, and PARKER, Circuit Judges

PER CURIAM:*

Carmen Saenz brought suit against Humana Health Plans of Texas, Inc. and Humana, Inc. (collectively "Humana") alleging various state causes of action.

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* Pursuant to Local Rule 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in Local Rule 47.5.4.

Humana contracts with the United States Office of Personnel Management (OPM) to provide health maintenance organization (HMO) services to federal employees under the Federal Employee Health Benefit Act (FEHBA). 5 U.S.C. § 8901 et seq. Appellant alleged that Humana unreasonably delayed payment of claims and refused to cooperate with Mrs. Saenz during her treatment for terminal bone cancer. The district court held that all of appellant's state claims were preempted by FEHBA's preemption provision, 5 U.S.C. § 8902(m)(1), and entered summary judgment for Humana. Our decision in *Burkey v. Government Employees Hosp. Ass'n*, 983 F.2d 656 (5th Cir. 1993) compels this result, and we affirm.

Carmen Saenz worked in Corpus Christi as an employee of a U.S. Congressman. Through her employment with the federal government, Mrs. Saenz selected Humana as her health insurance provider. She was diagnosed in November 1992 with a form of bone cancer.

Mrs. Saenz was treated at M.D. Anderson Hospital in Houston until July 1993, when a bone cancer specialist there recommended a special chemotherapy regimen. Humana refused to pre-certify treatment at M.D. Anderson on the grounds that Mrs. Saenz could receive the treatment locally in Corpus Christi. Mrs. Saenz was dissatisfied with that option, and she appealed Humana's decision to OPM. The parties dispute whether Humana responded to the appeal and whether OPM initially ruled on the appeal. In the summer of 1994, Mrs. Saenz submitted to OPM new information about her treatment. Subsequently, Humana convened a grievance committee and

conducted a hearing. This grievance committee apparently reversed Humana's earlier decision and paid for the treatment that Mrs. Saenz had already undergone.

Mrs. Saenz filed suit in Texas state court and Humana removed the case to federal district court.** Mrs. Saenz died during the pendency of this case, and appellant Priscilla Saenz was substituted as plaintiff below.

Appellant's suit is based on various acts related to Humana's solicitation of customers for its HMO plan and its handling of Mrs. Saenz' medical claims. Appellant refers in her brief to Humana's denial of coverage for the M.D. Anderson treatment and alleged refusal to cooperate with plaintiff in arranging her treatment from October

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** Although appellant does not challenge subject matter jurisdiction, we note that appellant's amended complaint filed after removal confers federal jurisdiction by including a federal RICO claim. *See Kidd v. Southwest Airlines Co.*, 891 F.2d 540, 545-547 (5th Cir. 1990) (federal jurisdiction proper where plaintiff does not object to improper removal, amends complaint to include federal claim, and receives a "trial on the merits," which includes summary judgment disposition) (citing *Grubbs v. General Electric Credit Corp.*, 405 U.S. 699, 702, 92 S.Ct. 1344, 1347 (1972)). We do not decide if federal jurisdiction existed under any other theory. *Compare Goepel v. National Postal Mail Handlers Union*, 36 F.3d 306, 312-316 (3d Cir. 1994) (removal jurisdiction not proper on grounds that FEHBA completely preempts entire area of law) *and Howard v. Group Hosp. Serv.*, 739 F.2d 1508, 1510-12 (10th Cir. 1984) (removal jurisdiction in suit based on FEHBA contract lacking because federal government has no "articulable interest in the outcome") *with Caudill v. Blue Cross and Blue Shield of North Carolina*, 999 F.2d 74, 78 (4th Cir. 1993) (unique federal interest in suit related to FEHBA contract supports removal jurisdiction).

1993 through August 1994. In addition, appellant cites two examples of Humana's "abusive practices."

The first example occurred while Mrs. Saenz was hospitalized with a broken hip related to her cancer. Mrs. Saenz required surgery, but the surgery was delayed for several days. Appellant alleges that Humana attempted to have Mrs. Saenz moved, contrary to her best medical interest, from the hospital to a nursing home for three or four days while she was awaiting surgery in order to save the difference in room costs.

The second example appellant cites is a brochure distributed by Humana as a promotional item. The brochure includes a photo of a mother with her child, and the attached quotation attributed to the mother asserts that Humana ensured that the child always received the "best of care." Appellant claims that Humana violated this alleged express warranty because it did not attempt to obtain the "best of care" for Mrs. Saenz.

The federal district court allowed appellant to amend her pleadings to assert any possible cause of action against Humana. Appellant asserted numerous state common law and statutory causes of action*** as well as a RICO claim. The district court found that all of appellant's state law claims were preempted by FEHBA and that appellant failed to state a RICO claim. Appellant only raises the preemption issue on appeal.

*** Appellant's claims included bad faith and unfair dealing, fraudulent inducement, deceptive trade practices, and violations of the Texas insurance code.

FEHBA's preemption provision provides:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or regulation issued thereunder, to the extent that such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1). This court has previously interpreted the scope of the FEHBA preemption provision in *Burkey v. Government Employees Hosp. Ass'n*, 983 F.2d 656, 660 (5th Cir. 1993). In *Burkey*, the plaintiff sued her insurer for breach of contract under Louisiana law. *Id.* at 657-58. After a bench trial, the judge awarded plaintiff a monetary judgment including damages and attorneys' fees for unreasonable delay in paying insurance claims, as is authorized under Louisiana law. *Id.* at 659.

After noting that "[t]he weight of authority and most persuasive analysis supports the position that state law claims are preempted," the *Burkey* court held that the Louisiana statutory penalties for unreasonable delay in paying benefits were preempted by FEHBA and the plan contract. *Id.* at 659-60. The court first cited the policy interest in "nationwide uniformity of the administration of FEHBA benefits." *Id.* at 660. Turning to the plaintiffs' claims, the court wrote:

> The Burkeys argue that their state law claim for penalties is not preempted under § 8902(m)(1) because their claim relates to remedies and not to the "nature and extent of coverage or benefits." No such distinction can sensibly be made. Tort claims arising out of the manner in which a

> benefit claim is handled are not separable from the terms of the contract that governs benefits. . . . Moreover, such claims "relate to" the plan under § 8902(m)(1) as long as they have a connection with or refer to the plan.
>
> Insofar as the Burkeys' claim for statutory delay damages necessarily refers to GEHA's plan to determine coverage and whether the proper claims handling process was followed, it refers to the plan, "relates to" it and is therefore preempted. Further, preemption is required because imposition of Louisiana's statutory penalties would invariably expand GEHA's obligations under the terms of its plan and would foster interstate conflicts in coverage.

Id. at 660 (citations omitted). The district court relied on *Burkey* in deciding that FEHBA preempts appellant's causes of action arising out of Humana's handling of Mrs. Saenz' claims for benefits.

Appellant's first argument is that his state law causes of action are not inconsistent with FEHBA or the plan provisions, and as a result are not preempted. As an example, appellant notes that a bad faith and unfair dealing claim under Texas law requires a plaintiff to prove that there was no reasonable basis for denial of a claim or for delay in payment of benefits, *See National Union Fire Ins. Co. v. Dominguez*, 873 S.W.2d 373 (Tex. 1994). Accordingly, appellant contends, if there is nothing in the plan that allows Humana to unreasonably deny claims, then the bad faith and unfair dealing claim is not preempted because it is not inconsistent with the plan. We disagree.

As the *Burkey* court noted, application of state legal remedies would "invariably expand" Humana and other insurers' obligations under the plan and would "foster interstate conflicts" in plan administration. 983 F.2d at 660. Appellant's bad faith and unfair dealing claim under Texas law is similar to the claim based in Louisiana law that *Burkey* held was preempted. *Compare* La. Rev. Stat. Ann. 22:657.A. (West Supp. 1992) *with Vail v. Texas Farm Bureau Mutual Ins. Co.* 754 S.W.2d 129, 137 (Tex. 1988). OPM provides a procedure for review of claim denials and delays, and the imposition of liability under a state cause of action based on the reasonableness of a claim denial can not avoid duplication of and conflict with OPM review.

Appellant also argues that claims for fraudulent inducement can not be preempted because at the time of the alleged misrepresentation, no plan contract was in place to conflict with. However, other circuits, in decisions cited with approval in *Burkey,* have held misrepresentation-based claims to be preempted by FEHBA under the uniformity of administration rationale. *See Hayes v. Prudential Ins. Co. of America,* 819 F.2d 921, 925-26 (9th Cir. 1987) (holding common law fraud claim preempted), *cert. denied,* 484 U.S. 1060 (1988). In addition, we have held that fraudulent inducement claims against an insurer related to advertising are preempted under ERISA. *Hubbard v. Blue Cross & Blue Shield Assoc.,* 42 F.3d 942, 946-47 (5th Cir.), *cert. denied,* ___U.S.___, 115 S.Ct. 2276 (1995). Applying this rule to FEHBA claims makes particular sense given the OPM must approve all materials used to solicit customers for the plan.

Appellant next contends that the decision in *Variety Corp. v. Howe*, ___U.S.___, 116 S.Ct. 1065 (1996), holding that ERISA plan administrators violated a fiduciary duty owed to plan beneficiaries, indicates that there is a comparable fiduciary duty to FEHBA beneficiaries. However, appellant did not claim breach of fiduciary duty in the district court. We do not address claims or arguments raised for the first time on appeal. *Hulsey v. Texas*, 929 F.2d 168, 171 (5th Cir. 1991).

Appellant's underlying theme, simply stated, is that the *Burkey* court was wrong and Congress did not intend to preempt state tort causes of action related to the administration of claims. Appellant points to other statutes granting federal causes of action to minorities and persons with disabilities who have been discriminated against and argues that Congress would not have given so many rights to those individuals while denying federal employees the right to sue their medical insurers in state court.

We are not in a position to question the wisdom of the policy choices made by Congress. The plain language of the FEHBA statute bars appellant's claims. Furthermore, Congress did not leave federal employees unprotected: it set up a comprehensive program to provide subsidized health care to federal employees with extensive regulations administered by OPM designed to protect their interests. OPM extracts conditions from insurers who contract under FEHBA and OPM is empowered to make the ultimate decision on any coverage dispute.

The *Burkey* court correctly interpreted the language of the FEHBA preemption provision and the intent of Congress. Furthermore, appellant's major arguments are in vain, because even if we disagreed with the *Burkey* decision, we can not overrule another panel of this court. *Pruitt v. Levi Strauss Co.*, 932 F.2d 458, 465 (5th Cir. 1991).

For the foregoing reasons, we AFFIRM the judgment of the district court.

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 96-40111

PRISCILLA SAENZ, As personal representative of the Estate of Carmen Saenz, Deceased substituted in place of CARMEN SAENZ, and Robert Saenz, as next friend of Carmen Saenz

Plaintiff - Appellant

v.

HUMANA HEALTH PLAN OF TEXAS INC, doing business as Humana Health Plan of Corpus Christi

Defendant - Appellee

Appeal from the United States District Court for the Southern District of Texas, Corpus Christi

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ON PETITION FOR REHEARING

(Filed Jan. 10, 1997)

Before JOLLY, JONES and PARKER, Circuit Judges.

PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above case is denied.

ENTERED FOR THE COURT:

/s/ Edith H. Jones
United States Circuit Judge

1/10/97

THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
CORPUS CHRISTI DIVISION

CARMEN SAENZ	§	
	§	
V.	§	C.A. NO. C-95-17
	§	
HUMANA HEALTH PLANS	§	
OF TEXAS, INC. and	§	
HUMANA, INC.	§	

ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

(Filed Jan. 10, 1996)

The defendants, Humana Health Plans of Texas, Inc. ("Humana Health") and Humana, Inc. ("Humana"), contract with the United States Office of Personnel Management (OPM) to provide HMO services to federal employees under the Federal Employee Health Benefit Act (FEHBA). 5 U.S.C. § 8901. Plaintiff Carmen Saenz was a terminally ill cancer victim enrolled under a FEHBA plan. The parties' suit concerns a partial denial of benefits. The plaintiff asserts various state law claims, along with claims under the RICO statute. 18 U.S.C. § 1961 *et seq.* The defendants move to dismiss the plaintiff's complaint, or in the alternative, for summary judgment.

A. Preemption by FEHBA

FEHBA contains a clear preemption provision which states:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with

> respect to benefits) shall supersede and preempt any state or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1). The FEHBA preemption provision completely preempts state law tort claims that arise out of a failure or delay in payment benefits. *Burkey v. Government Employees Hosp. Ass'n,* 983 F.2d 656, 660 (5th Cir. 1993). The plaintiff's state law claims arise from the defendants' delay in payment of benefits, and are therefore "inconsistent with" the contractual provisions of the plan. The Court grants the defendants' summary judgment on the plaintiff's state law claims asserted against the defendants.

Plaintiff contends that Humana may not avail itself of FEHBA's preemption and cites two ERISA cases. *Hubbard v. Blue Cross & Blue Shield Ass'n,* 42 F.3d 942, 946-47 (5th Cir.), *cert. denied,* 115 S.Ct. 2276 (1995); *Perkins v. Time Ins. Co., Inc.,* 898 F.2d 470, 473 (5th Cir. 1990). The Court disagrees. Humana, as the parent company of the insurer Humana Health, may invoke FEHBA preemption because the claims against Humana, unlike the claims asserted against the non-ERISA entity in *Hubbard,* implicate the plan's administration and benefits. *Hubbard,* 42 F.3d at 947. Inasmuch as the plaintiff alleges Humana "closely regulates and monitors the operations of Humana Health," FEHBA preemption applies to claims the plaintiff asserts against Humana as well.

B. Plaintiff's RICO Claim

Plaintiff alleges that the defendants have committed various acts of mail and wire fraud, and in doing so have violated the RICO statute, 18 U.S.C. § 1961 *et seq. See* Plaintiff's Am. Compl. at ¶ XLIV. Although not specific about the various subsections of RICO the defendants have allegedly violated, the plaintiff appears to allege in her generalized complaint that the defendants have violated subsection (c), which prohibits a person employed by or associated with an enterprise to conduct the affairs of the enterprise through a pattern of racketeering activity, and subsection (d) which prohibits conspiracies to violate RICO. The core of a RICO claim is a (1) a person who engages in (2) a pattern of racketeering activity which is (3) connected to the acquisition, establishment, conduct, or control of an enterprise. 18 U.S.C. § 1962; *Delta Truck & Tractor Inc. v. J.I. Case Co.*, 855 F.2d 241, 242 (5th Cir. 1988), *cert. denied*, 109 S.Ct. 1531 (1989). RICO defines an "enterprise" as "any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity. . . . " 18 U.S.C. § 1961(4). A RICO "person" must be distinct from the "enterprise" for the purposes of § 1962(c). *In re Burzynski*, 989 F.2d 733, 743 (5th Cir. 1993).

Plaintiff admits in her complaint that Humana is the parent corporation of Humana Health. Plaintiff's Am. Compl. at ¶ VII. The plaintiff claims that Humana Health, its parent Humana, and an employee of Humana Health (Dr. Olsen) are the "persons" which form the RICO "enterprise." The plaintiff appears to claim that these defendants form an association in fact under 18 U.S.C.

§ 1961(4), and therefore constitute a RICO "enterprise." The plaintiff does not allege in her generalized complaint, however, that these parties were associated in any manner apart from the activities of Humana's health insurance businesses. The predicate acts which the plaintiff identifies as the core of the RICO violation all occur in the context of the defendants' health insurance businesses. As a result, the Court finds Humana, Humana Health, and Dr. Olsen to be one "person" for the purposes of the plaintiff's RICO claim. If these persons are the only entities that compose the RICO enterprise, the plaintiff's RICO claims fail. *Atkinson v. Anadarko Bank & Trust Co.*, 808 F.2d 438, 441 (5th Cir.) (bank's holding company, the wholly-owned bank, and three bank employees were not an "entity separate and apart from the bank," and were therefore not a RICO "enterprise"), *cert. denied*, 107 S.Ct. 3276 (1987).

To avoid this ruling, the plaintiff identifies "innocent third parties" – such as the health care providers and the plan beneficiaries – as components of the RICO enterprise. Innocent third parties cannot be members of a RICO enterprise because they have not joined knowingly in the scheme as the law requires. *See United States v. Angiulo*, 847 F.2d 956, 964 (1st Cir.), *cert. denied*, 109 S.Ct. 138 (1988). The Court grants the defendants' motion for summary judgment on the plaintiff's RICO claim under 18 U.S.C. § 1962(c) and (d).

ORDERED this 1 day of Jan, 1995.

/s/ H. W. Head Jr.
H. W. HEAD, JR.
UNITED STATES
DISTRICT JUDGE

THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
CORPUS CHRISTI DIVISION

CARMEN SAENZ	§	
	§	
V.	§	C.A. NO. C-95-17
	§	
HUMANA HEALTH PLANS	§	
OF TEXAS, INC. and	§	
HUMANA, INC.	§	

FINAL JUDGMENT

(Filed Jan. 10, 1996)

The Court hereby renders final judgment for the defendants on claims asserted by the plaintiff. The Court awards costs to defendants.

ORDERED this 9 day of Jan, 1996.

/s/ H. W. Head Jr.
H. W. HEAD, JR.
UNITED STATES
DISTRICT JUDGE

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
CORPUS CHRISTI DIVISION

PRISCILLA SAENZ AS PERSONAL REPRESENTATIVE OF THE ESTATE OF CARMEN SAENZ, DECEASED	)	CIVIL ACTION NO. C-95-17
Plaintiff	)	
V.	)	
HUMANA HEALTH PLAN OF TEXAS, INC. D/B/A HUMANA HEALTH PLAN OF CORPUS CHRISTI AND HUMANA, INC.	)	
Defendants	)	

ORDER SUBSTITUTING PARTIES

(Filed Feb. 22, 1996)

The Court hereby grants the Plaintiff's Motion to Alter Judgment and Substitute Parties. IT IS THEREFORE ORDERED that the Plaintiffs in this cause, Carmen Saenz and Robert Saenz, as Next Friend of Carmen Saenz, shall be substituted and that the Estate of Carmen Saenz by and through its Personal Representative, Priscilla Saenz shall from this point forward be the party plaintiff in this cause.

SIGNED AND ENTERED this the 22 day of Feb, 1996.

/s/ H. W. Head Jr.
H. W. HEAD, JR.
UNITED STATES
DISTRICT JUDGE

Supreme Court, U.S.
FILED
MAY 23 1997
CLERK

No. 96-1618

IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

PRISCILLA SAENZ, AS PERSONAL REPRESENTATIVE OF THE ESTATE OF CARMEN SAENZ, DECEASED,
Petitioner,
v.
HUMANA HEALTH PLAN OF TEXAS, INC., DOING BUSINESS AS HUMANA HEALTH PLAN OF CORPUS CHRISTI AND HUMANA, INC.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTION RESTATED

Should the Petition be granted to review the Fifth Circuit Court of Appeals' holding that the Federal Employee Health Benefits Act's preemption provision, 5 U.S.C. 8902(m)(1), preempts petitioner's state law claims?

STATEMENT REQUIRED BY RULE 29.6

The parent company of Humana Health Plan of Texas, Inc. d/b/a Humana Health Plan of Corpus Christi is Humana, Inc. Humana, Inc. has no parent company. Neither entity has any non-wholly owned subsidiaries.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

No. 96-1618

PRISCILLA SAENZ, AS PERSONAL REPRESENTATIVE OF THE ESTATE OF CARMEN SAENZ, DECEASED,
Petitioner,

v.

HUMANA HEALTH PLAN OF TEXAS, INC., DOING BUSINESS AS HUMANA HEALTH PLAN OF CORPUS CHRISTI AND HUMANA, INC.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

RESPONDENTS' BRIEF IN OPPOSITION

Petitioner, Priscilla Saenz, As Personal Representative of the Estate of Carmen Saenz, Deceased ("Saenz"), seeks review of a decision of the United States Court of Appeals for the Fifth Circuit in *Saenz v. Humana Health Plan of Texas, Inc. et al.*, No. 96-40111 (5th Cir. Dec. 12, 1996) (per curiam), *petition for cert. filed*, 65 U.S.L.W. 41 (U.S. Apr. 10, 1997) (No. 96-1618).[1] By its decision,

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[1] All references to Petitioner's Petition for Writ of Certiorari will be cited as "Pet.", e.g., "Pet. 1". For the convenience of the Court, all citations to the Fifth Circuit's opinion below are contained in the Petition's Appendix and cited as "Pet. App.", e.g., "Pet. App. 1". All references to the Appellate Record are referenced with the term "Rec.", e.g., "Rec. Vol. 1, p. 1".

the Fifth Circuit upheld a summary judgment denying Saenz's claims which arise out of certain health benefits sought by Carmen Saenz from her health plan, Humana Health Plan of Texas, Inc. d/b/a Humana Health Plan of Corpus Christi ("Humana Health"). In light of the misstatement of facts by the petitioner and her heavy reliance upon factual allegations from the trial pleadings which are unsubstantiated by the record, respondents provide the following Counterstatement.

COUNTERSTATEMENT OF THE CASE

Carmen Saenz, a federal employee in Corpus Christi, Texas, was a member of a health maintenance organization ("HMO") offered by Humana Health to federal employees. Under the Federal Employee Health Benefit Act (FEHBA), 5 U.S.C. 8901, *et seq.*, Humana Health contracts with the United States Office of Personnel Management ("OPM") to provide a medical plan to federal employees such as Ms. Saenz. Rec. Vol. 2, pp. 314-316. The HMO and Ms. Saenz's relationship was generally governed by a 20 page contract (the "Plan Document"). Rec. Vol. 2, pp. 509-529 & 540-560. As set forth in the Plan Document, Humana Health's HMO "arranges in advance with specific doctors and hospitals to give care to members and pays them directly for their services." For Ms. Saenz's medical care to be covered under the HMO, she had to obtain medical care from "Plan providers except in a medical emergency". The Plan also required that the participant's primary care physician request preauthorization from Humana Health prior to any hospitalization or referral to a specialist. Rec. Vol. 2, pp. 514 & 515.

In this case, on September 2, 1993 (not the summer of 1993 as petitioner states), Ms. Saenz's primary care physician requested pre-authorization for admission of Ms. Saenz to The University of Texas M.D. Anderson Cancer Center in Houton, Texas. Houston is over 150 miles from Corpus Christi and is outside of Ms. Saenz's plan's pro-

vider network. As a result, Humana Health denied Ms. Saenz coverage for a proposed September 15, 1993 admission to M.D. Anderson. Rec. Vol. 2, p. 571. The denial was made promptly and was explained in a September 15, 1993 letter to Ms. Saenz by Humana Health's medical director. As noted in the letter, it was the medical director's understanding that cancer specialists in the health plan's provider network could provide Ms. Saenz the care she needed. Rec. Vol. 2, p. 277. Despite Humana Health's denial of benefits, Ms. Saenz opted to proceed with the chemotherapy treatment scheduled at M.D. Anderson. Rec. Vol. 2, p. 572. She continued to receive treatment at M.D. Anderson as late as 1995, and testified she did not discontinue any cancer therapy at M.D. Anderson because Humana Health was not paying. Rec. Vol. 2, pp. 576-580 & 629.

Under Ms. Saenz's FEHBA health plan, she had the right to request reconsideration by Humana Health of the denial of benefits and, ultimately, she could appeal the denial to OPM, the agency empowered to reverse decisions of the health plan. Rec. Vol. 2, p. 526. Ms. Saenz did in fact request reconsideration by Humana Health and eventually appealed the denial to OPM. On August 22, 1994, based on newly discovered information, Humana Health reversed its initial denial and authorized payment to M.D. Anderson. Rec. Vol. 2, p. 572. Humana proceeded to pay M.D. Anderson and other related providers covered charges of $51,715 for services dating back as far as September 16, 1993. In light of Humana Health's reversal of its denial of the benefits of Ms. Saenz's chemotherapy treatment at M.D. Anderson, OPM completed its review of Carmen Saenz's appeal. Rec. Vol. 2, p. 582.

Under the Plan Document approved by OPM, any dispute regarding the Plan's "benefits or coverage or payments with respect to those benefits", is governed by federal law. As OPM has the power to reverse Humana Health's denial, judicial review of any matter that relates to benefits, coverage or payment of benefits is limited to

a review of a final decision of OPM. Under the Plan Document, a claimant's recovery in such a lawsuit is limited to "contract benefits in dispute, plus simple pre-judgment interest . . . and court costs." Rec. Vol. 2, p. 526.

Despite the fact that the covered benefits had been paid, and contrary to the provisions of the Plan Document governing the relationship between Saenz and Humana Health, Saenz instituted suit in a Texas state court on December 21, 1994 alleging that "Humana refused to pay" for treatment at M.D. Anderson and that it breached "its obligations under the Plan". Based on this alleged breach and refusal to pay, Saenz also asserted extra-contractual bad faith claims and sought damages other than those allowed under the Plan Document. Humana Health answered stating that all of Saenz's claims were preempted by virtue of FEHBA's preemption provision, 5 U.S.C. § 8902(m)(1). Rec. Vol. 3, pp. 1169-1183. Humana Health then removed the case to U.S. District Court and sought dismissal of all of Saenz's claims by a Motion to Dismiss and a Motion for Summary Judgment. The Court permitted Saenz to amend her pleadings to which she responded by enlarging her pleading to contain a number of additional extra-contractual claims as well as a claim under the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. § 1961-1968. Rec. Vol. 2, pp. 676-706. Saenz also named Humana, Inc., Humana Health's parent company, as a party Defendant.

The U.S. District Court, after considering Defendants' Amended Motion to Dismiss and Motion for Summary Judgment, held that "[t]he Plaintiff's state law claims arise from Defendants' delay in payment of benefits, and are therefore 'inconsistent' with contractual provisions of the Plan." As such, the Court granted summary judgment against Saenz on all her state law claims. The Court also granted Humana's Motion for Summary Judgment on Plaintiff's RICO claim. Pet. App. 13.

During the pendency of the case, Carmen Saenz died and her daughter, Priscilla Saenz, substituted in to represent her interest in the case. Priscilla Saenz sought appeal of the case to the U.S. Court of Appeals for the Fifth Circuit. Briefs were submitted by the parties and, on December 12, 1996, nine days after oral argument, the court of appeals affirmed by per curiam opinion the U.S. District Court's holding.

In her Statement of the Case, petitioner summarizes a number of *alleged* acts (*See* Pet. 5-6) which are not supported by the summary judgment proof, are factually incorrect, and constitute misrepresentations to which objection is made pursuant to Supreme Court Rule 15.2. Further, regardless of the preemption of the claims, the allegations fail to provide a basis for any claim and are merely an attempt to disparage the respondents by false statements and innuendos of malfeasance. The record contains no evidence to support the allegations pled, as required in the face of the Humana Defendants' Motion for Summary Judgment,[2] and, as they are offered as statements of fact, they are denied. For example, Humana did not represent that it would provide "the best of health care" and the comparison of this statement to the testimony within the deposition of the health plan executive director (which is not within the record) is incorrect and misleading. Second, the medical director for the health

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[2] Respondents sought and obtained dismissal in the district court pursuant to Federal Rule of Civil Procedure 12(b)(6) (dismissal for "failure to state a claim upon which relief may be granted") and Rule 56 (dismissal by summary judgment). The district court granted Summary Judgment based on preemption of the state law claims alleged. While many of the factually incorrect pleadings, even taken as true, do not support the elements of a cause of action, they are addressed herein to the extent they are relevant to an alternative motion for summary Judgment claim sought in the district court because petitioner cannot support the elements of her causes of action under *Celotex Corp. v. Katrett*, 477 U.S. 321 (1986).

plan did not admit "lying" to Carmen Saenz about the treatment to be received and no evidence in the record presented even implies such an action. Third, no evidence is provided that Humana Health gave incentives to primary care physicians to avoid hospitalization of HMO members. This issue is not determinative of any element of petitioner's claim nor is it factually correct. Any financial incentives given to a primary care physician in this area is provided to ensure referrals are made efficiently and effectively, not to deter the hospitalization of patients that need hospitalization. Fourth, petitioner's allegation that Humana Health requires primary care physicians to perform services they are not qualified to do is a misstatement. As noted in the Plan Document, the primary care doctor will refer, when necessary, the participant to specialists. The requirement that a primary care physician make the referral to the specialist was disclosed at numerous points in the Plan Document. Rec. Vol. 2, pp. 514, 515 & 528. Therefore, this contention provides no support for the ultimate contention made in petitioner's Statement of Facts that Carmen Saenz would not have become a member of the health plan if she had known that she would have to receive a referral from a primary care physician before she went to an oncologist. The Plan Document clearly sets forth this information and there is no evidence in the record to the contrary. Fifth, there is nothing in the record to substantiate petitioner's statement that Humana in any way refused to disclose the name of any physicians who reviewed whether the treatment could be provided in the network. Sixth, as for the moving of Ms. Saenz to a nursing home during the period that the orthopedic surgeon had to wait for a particular hip pin to be delivered, there is no credible evidence within the record that it was inappropriate for Ms. Saenz to move to a nursing facility while she was waiting for the hip pin. Additionally, the treating physician made the referral of the patient to the nursing home and Humana Health pro-

vided benefits for that service. Accordingly, petitioner's statement is a mischaracterization of the facts in the case. Regardless, as will be addressed, these unsubstantiated allegations are a passel of red herrings alleged in the trial court, not as the true complaint of petitioner, but as a desperate attempt to "muddy the water" to save the case from dismissal.

REASONS FOR DENYING THE WRIT

I. THE OVERWHELMING WEIGHT OF AUTHORITY SUPPORTS THE FIFTH CIRCUIT'S HOLDING THAT FEHBA PREEMPTS PETITIONERS' STATE LAW CLAIMS.

Saenz's petition should be denied for the same reasons that this Court denied the petition for writ of certiorari in *Hayes v. Prudential Ins. Co. of America*, 819 F.2d 921 (9th Cir. 1987) *cert. denied*, 484 U.S. 1060 (1988), approximately nine years ago. Just as the insured did in *Hayes*, petitioner urges that her claims of bad faith and unfair dealing, fraudulent inducement, deceptive trade practices and violations of the Texas Insurance Code are not preempted by the FEHBA preemption provision, 5 U.S.C. § 8902(m)(1). In *Hayes*, the Ninth Circuit held that all of these causes of action, as well as breach of contract, civil conspiracy, and breach of fiduciary duty, are preempted under FEHBA. *Id.* at 926. Since the time that this Court denied the petition for writ of certiorari in *Hayes*, Congress has not amended FEHBA's preemption provision nor has this Court or a United States Court of Appeals held that similar claims of health plan participants are not preempted.

Three United States Court of Appeals have *directly* addressed the issue requested to be reviewed by Saenz, and have held FEHBA preempts a plan participant's extra-contractual state law claims. *See Hayes, supra*; *Burkey v. Government Employees Hospital Ass'n.*, 983 F.2d 656, 657-58 (5th Cir. 1993) (claim for doube dam-

ages and attorney's fees for unreasonable delay in paying health and accident insurance claims under Louisiana law held to be preempted by FEHBA); *Myers v. United States*, 767 F.2d 1072, 1074 (4th Cir. 1985) (health plan participants' bad faith claim against health insurer under South Carolina law held to be preempted by FEHBA). In addition to the foregoing, in the other courts of appeals cases addressing FEHBA preemption, three other courts have held FEHBA preempts all state law claims presented in those respective cases. *See Harris v. Mutual of Omaha Cos.*, 992 F.2d 706, 711-12 fn. 1 (7th Cir. 1993) (due to FEHBA preemption, federal law controls over Indiana law in the interpretation of health insurance contract); *Nesseim v. Mail Handlers Benefit Plan*, 995 F.2d 804, 806 (8th Cir. 1993) (FEHBA preemption provision mandates that FEHBA health plan has the preemptive force of federal law); *Blue Cross and Blue Shield v. Florida Department of Banking*, 791 F.2d 1501, 1505 (11th Cir. 1986) (due to FEHBA preemption, health plan's contract preempts Florida state law); *Tackitt v. Prudential Ins. Co. of America*, 758 F.2d 1572, 1575 (11th Cir. 1985) (interpretation of right to home health care benefits under a FEHBA contract is controlled by federal and not state law due to FEHBA preemption); *see also Caudill v. Blue Cross and Blue Shield of North Carolina*, 999 F.2d 74, 79 (4th Cir. 1993) (while not relying on the FEHBA preemption provision, federal common law held to entirely replace state contract law in the interpretation of a FEHBA health plan).

In an attempt to convince this Court to consider granting her petition, Saenz states that there is a "conflict in the opinions of various appellate courts" on the issue ruled on by the Fifth Circuit below that FEHBA preempts all of petitioner's state law claims. Pet. 2. Later in her petition, however, Saenz states, "[t]o date, the ruling of the lower courts, with one exception, have been that every state court cause of action brought to their attention in a FEHBA case has been preempted." Pet. 18. Petitioner

then cites the "one exception", *Howard v. Group Hospital Service*, 739 F.2d 1508 (10th Cir. 1984), which, while peripherally addressing FEHBA preemption, did not directly address the issue of whether state law contractual and extra-contractual claims are preempted by FEHBA. The Tenth Circuit in *Howard* primarily addressed whether the court had jurisdiction to hear the case under federal common law and, in finding that it did not, cited Section 8902(m)(1) in a footnote and noted only that "there is no indication" that an Oklahoma law conflicts with the health plan contract. *Howard*, 739 F.2d at 1510. Accordingly, *Howard* is not a case which supposedly creates a conflict of "various federal appellate courts" as cited by petitioner.[3]

Even if *Howard* could be considered "a conflicting opinion", it was rendered before the other opinions reviewing FEHBA preemption, it did not directly address the issues before the Fifth Circuit in *Saenz*, and it is contrary to the holdings of six other United States courts of appeals. In light of the precedent of the numerous circuit courts, as well as the denial of a previous petition for writ of certiorari in *Hayes*, petitioner's request for review by this Court serves only to prolong litigation over an issue wherein numerous courts have exhaustively analyzed FEHBA preemption and have generally arrived at the same conclusion: FEHBA health plans preempt state law contract and extra-contractual claims. In light of the filing of the petition, however, respondents will again address the issues raised before the lower courts.

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[3] The Fifth Circuit in *Burkey*, when surveying the opinions which hold FEHBA preempts state law claims, did acknowledge one circuit "held otherwise", referring to *Howard*. *Burkey*, 983 F.2d at 659. In doing so, howeevr, the court spoke in general terms and did not review the *Howard* opinion in depth. *Howard's* lack of any strong reliance on the interpretation of FEHBA's preemption provision reveals that it is hardly a conflicting opinion.

II. THE FIFTH CIRCUIT PROPERLY CONSTRUED THAT CONGRESS' INTENT IN ENACTING FEHBA'S PREEMPTION PROVISION WAS TO INSURE UNIFORMITY IN THE ADMINISTRATION OF FEDERAL EMPLOYEE HEALTH BENEFITS.

A. Legislative History and Statutory Language.

Petitioner basically contends that FEHBA's preemption provision has been misconstrued by the numerous appellate courts which have determined its scope. Petitioner contends that the courts are wrong in their analysis, arguing that FEHBA preemption is limited to contract claims and that it does not cover extra-contractual claims. Petitioner, however, ignores the legislative history relied on by the Fifth Circuit in *Saenz* and the other cases which have analyzed the breadth of FEHBA preemption.

In 1978, Congress amended FEHBA to include a preemption provision. By the preemption provision, the provisions of any FEHBA contract "which relate to the nature or extent of coverage or benefits" supersede and preempt any state laws inconsistent with the provisions of the contract. 5 U.S.C. § 8902(m)(1). Recognizing that a "program established by an act of Congress [ ] should not be subject to alterations or regulations by State legislatures or State insurance boards," H.R. Rep. No. 282, 95th Cong., 1st Sess. 4 (1977), Congress enacted § 8902(m)(1) for the sole "purpose of . . . establish[ing] uniformity in benefits and coverage under the Federal Employee's Health Benefits Program." S. Rep. No. 903, 95th Cong., 2nd Sess. 2, *reprinted in* [1978] U.S. Code Cong. & Admin. News 1413. Relying on Congress' specific intent to "ensure nationwide uniformity of the administration of FEHBA benefits," numerous cases have held FEHBA contracts preempt state law claims of health plan participants. *Burkey*, 983 S.W.2d at 660 (citing cases relying on Congress' intent to provide uniformity).

The construction given the preemption provision by the majority of courts construing the provision is consistent

with Congress' intent when it authorized the federal government to wade into the area of the administration of group health benefits for government employees. In the creation of the right of federal employees to join a health plan which provides benefits at a cost "generally charged for new group health benefit plans issued to large employers" in the private sector, 5 U.S.C. § 8902(i), checks and balances were built into the entire statute and regulatory process governing most every area of the administration of benefits to federal employees. For example, Humana Health must adhere to FEHBA and OPM contract requirements such as: (1) any brochure regarding benefits of Humana Health has to be approved by OPM; (2) if Humana Health does not maintain sufficient financial resources, facilities, providers, staff and other necessary resources to meet the obligations of a FEHBA contract, it may be suspended by decision of OPM; (3) Humana Health ceded all final decision making on disputed claims to OPM pursuant to 5 U.S.C. § 8902(j); (4) Humana Health agreed to provide benefits to federal employees at a rate equivalent to "that charged to the total community rated membership of the carrier", that is, health plans offered to employees in the private sector; (5) Humana Health must submit to OPM for "prior approval" any supplemental literature to be distributed at federal facilities to determine whether it is in compliance with FEHBA regulations as to misleading, deceptive, or unfair advertising; and (6) Humana Health must allow federal employees to enroll in the plan regardless of preexisting conditions under 5 U.S.C. § 8902(f). Rec. Vol. 2, pp. 319, 320, 322, 328, 329, 408A, & 446.

Also, numerous regulations govern the relationship between OPM, the health plan and the federal employee as promulgated under the authority granted to OPM by Congress in 5 U.S.C. 8913. *See* 5 C.F.R. 890 *et seq.* Under the administrative process, Congress delegated to OPM the authority to interpret health benefit contracts and, as stated, to make the final decision regarding whether bene-

fits should be paid or not. As noted by the Fifth Circuit in its opinion in *Saenz*,

> OPM provides a procedure for review of claims, denials and delays and the imposition of liability under a state cause of action based on the reasonableness of a claim denial cannot avoid duplication of and conflict with OPM review.

Pet. App. 7. Congress' intent to preempt state laws such as those giving rise to the claims in *Saenz* (as well as the other cases cited above), is clearly indicated by the creation of the preemption provision and the OPM review process. What Saenz proposes, to limit preemption to claims for actual benefits and allow a second avenue for relief through the state courts on extra-contractual claims, would render Congress' enactment of the preemption provision meaningless. To allow the adjudication of extra-contractual claims would foster interstate rivalries in coverage by subjecting different federal employees to differing rights and remedies. If Saenz's proposal were adopted, the uniformity envisioned by Congress would be wholly defeated.

B. FEHBA Plan's Language and Preemption.

Saenz urges this Court to review FEHBA's preemption provision and specifically its "inconsistent with" language. In support of this request, Saenz states "no federal appellate court has considered to what extent state laws . . . are or could be inconsistent with the language of an insurance policy. . ." Pet. 28-29. This is a misstatement. In *Hayes v. Prudential Life Ins. Co. of America*, the court expressly held that state law claims which "invariably expand [the health plan's] obligations under the terms of the Plan . . . are *inconsistent with the Plan* and, hence, preempted under § 8902(m)(1)." *Hayes*, 819 F.2d at 926 (emphasis added).

Petitioner then proceeds to lead the Court through a series of mental gymnastics by comparing provisions of

the Plan Document and ignoring the policy stated in *Hayes* that state laws which enlarge the plan are inconsistent with it and, therefore, are preempted. For example, Saenz urges that because the Plan Document does not expressly permit bad faith and fraud, the contract is not "inconsistent with" state laws forbidding bad faith and fraud. Pet. 12. The "inconsistent with" language within the preemption provision, however, does not require the Plan Document to be an endless compilation of terms permitting certain actions which otherwise are forbidden by state statutes. The intention of the Plan Document is to set forth the general provisions of how the benefits are to be administered by the health plan and to be received by the federal employee. This ignores the previous holdings and the logical premise that allowing extra-contractual claims would only serve to expand the obligations of the carrier under the agreement and they would, therefore, be "inconsistent with" the terms of the plan.

Saenz tries another angle supposedly supporting her position by posing the question of what would happen if the health plan medical director unilaterally denies a claim, not based on the prevailing medical science at the time, but rather based on an unsubstantiated medical belief and thereby modifies the plan's obligation to follow generally accepted medical practice? Pet. 14-15. Saenz proposes that if Humana Health can modify the plan, then Saenz should likewise have the right to pursue a bad faith claim for an unjustified denial of benefits. These examples, like wild swings late in a prize fight, fail to hit the intended target. Saenz attempts to create rights in the agreement which are not evident from the agreement's terms and are inconsistent with the express terms of the Plan Document, the FEHBA statute, and OPM regulations. For instance, in the event the medical director failed to consider generally accepted medical practice in making a denial, the federal employee could immediately pursue his right to OPM review of the medical director's decision based on the rights set forth on page 18 of the Plan Document. By statute, OPM is vested with the

power to ensure that the federal employee receives the health service he "is entitled thereto under the contract." 5 U.S.C. § 8902(j). As such, if the medical director is wrong, OPM can order benefits to be paid. Therefore, the express provisions of the plan provide a remedy to the plan participant and the plan is not "modified" as suggested by Saenz.

In an attempt to show that her extra-contractual claims are not "inconsistent with" the contract, Saenz also refers the Court to the provisions in the Plan Document which state that (1) it is a criminal act for the participant to submit fraudulent claims and (2) the participant is to submit claims promptly for them to be considered. Pet. 11-12. Saenz appears to be contending that this language is support for her position that state laws which forbid fraud and bad faith are consistent with these plan provisions and are, therefore, not preempted. This argument ignores the provision of the Plan Document which states "[f]ederal law exclusively governs all claims for relief in a lawsuit that relate to this plan's benefits or coverage or payments with respect to those benefits." Rec. Vol. 2, p. 526. Consistent with Congress' intent, the only lawsuit which may be pursued is an appeal of OPM's final decision. Saenz argument, if carried to its illogical conclusion, would actually create a right of action which is inconsistent with the terms on page 18 of the Plan which (1) require OPM review, (2) limit lawsuits to judicial review of OPM's decision, and (3) limit damages in such actions to plan benefits, interests and court costs.

Petitioner also attempts to provide a restrictive interpretation of the Plan Document's dispute provisions on page 18 by stating that they only envision review of benefit disputes—not extra-contractual claims. Pet. 16-17. Again, petitioner misleads the Court by ignoring the express terms of the Plan Document which state: "Federal law exclusively governs *all* claims for relief in a lawsuit that *relate to* this Plan's benefits or *coverage or payment* with respect to those benefits." Rec. Vol. 2,

p. 526 (emphasis added). The foregoing language from the Plan Document tracks the terms of the FEHBA preemption provision. Plainly, this language is not limited to just the benefit determination but *also* issues which "relate to" benefits, coverage and payments. Like ERISA's preemption provision (which also contains the term "relate to"), the Plan Document and FEHBA's "relate to" phrase has been held to be determinative of the breadth of preemption. As noted in *Blue Cross and Blue Shield v. Florida Department of Banking*, 791 F.2d 1501, 1505 (11th Cir. 1986), like ERISA's use of the phrse "relate to",[4] FEHBA's use of the term "relate to" is similarly to be interpreted liberally to include state laws which have "any connection with or reference to such insurance or plans." Accordingly, Saenz's attempt to narrow the scope of FEHBA preemption by citing phrases of the plan's dispute provisions out of context fails when the light of day is put on the rest of the language of the provisions.

Saenz persists in her claim that, under the FEHBA preemption provision and the terms of the contract, Congress intended only for the right to benefits to be determined by OPM and that only contract benefits claims are preempted. Pet. 16-17. Saenz makes this argument urging that extra-contractual claims, such as bad faith, survive preemption as they are not expressly subject to OPM review. Saenz basically claims that preemption flows only to the benefit claim, a contract claim, and, thus, preemption of a benefit claim does not necessarily include the bad faith claim. This theory was rejected by this Court

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[4] In *Shaw v. Delta Airlines*, 463 U.S. 85 (1983), this Court reviewed ERISA's preemption provision which provides that ERISA preempts "any and all state law insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This Court determined that it "must give effect to this plain language unless there is good reason to believe Congress intended the language to have some more restrictive meaning." *Id.* at 96-97. The holding went on further to find that the term "relate to" means a state law is preempted "if it has a connection with or reference to such a plan."

in *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 200 (1985). *Allis-Chalmers* analyzed the applicability of the Labor Management Relations Act of 1947 (LMRA), 29 U.S.C. § 185, to the denial of an employee's health benefit claim. *Id.* at 206. The LMRA also has a preemption provision and requires that disputes be submitted to a grievance procedure before a lawsuit can be commenced. *Id.* Lueck skipped any grievance procedures and filed suit in state court alleging state law bad faith claims and seeking extra-contractual damages. The Wisconsin Supreme Court held that the LMRA did not preempt Lueck's bad faith claims because, "though a breach of duty exists as a consequence of the relationship established by contract, [the bad faith claim] is independent of that contract." *Id.* at 207. This Court reversed and held Lueck's bad faith claim was preempted stating that "[t]he duties imposed and rights established through the state tort thus derive from the rights and obligations established by the contract." *Id.* at 217. As such, "[s]ince the state tort purports to give life to [the contract] terms in a different environment, it is preempted." *Id.* at 219. *Allis-Chalmers*' reasoning was relied on heavily in *Hayes* and *Burkey* for this same proposition as applied in the FEHBA scenario. *See Burkey*, 983 F.2d at 660; *Hayes*, 818 F.2d at 926; *see also Saenz*, Pet. App. 6.

Despite the previous rulings of *Hayes*, *Burkey*, and the Fifth Circuit below, Saenz contends that the bad faith claims are separate and apart from the contract claim. The same concern in *Allis-Chalmers* about the effect of finding a bad faith claim to not be preempted holds true in *Saenz*. While in *Allis-Chalmers* it is the arbitrator's role which is rendered meaningless by an employee restating his contract claim in the form of a tort claim, in *Saenz*, it is OPM which will be bypassed by a government employee doing the same, thereby defeating the purpose of having nationwide uniformity of the administration of FEHBA benefits. This Court's express position in *Allis-Chalmers* relates directly to the same issues

raised by *Saenz* and, as such, petitioner's claims of a dual remedy, one outside OPM and one under state law, if adopted, would render Congress' action in creating FEHBA's safeguards and preemption meaningless.

Saenz similarly contends that the appeal right of a participant to OPM does not provide a sufficient remedy and then sets forth the implausible example of an AIDS patient whose claim is "unjustifiably denied" because his insurer believed he would not have "sufficient resources" to pursue a claim before he died. Pet. 22. As noted in *Kobleur v. Group Hospitalization & Med. Services*, 954 F.2d 705, 711 (11th Cir. 1992), the delegation of authority to OPM to review denied claims is proof of "Congress' faith in OPM's ability to protect federal employees through its administration of the program." Therefore, the relief necessary to protect the government employee, as determined by Congress, is available in the power of OPM to unilaterally review and, if necessary, reverse a health plan's denial.

C. Comparison of FEHBA to Other Statutes.

Saenz attempts to compare the Americans With Disability Act (ADA), 42 U.S.C. § 12101, *et seq.* and the "Civil Rights Act of 1964, 29 U.S.C. § 1001, *et seq.* [sic]" [5] to FEHBA contending Congress could not have possibly intended to allow for extra-contractual damages under the Civil Rights Act and the ADA and afford something less to federal employees denied health benefits. Pet. 24-25. This argument ignores that Congress specifically afforded a complaining party under the ADA and the Civil Rights Act the right to "recover compensatory and punitive damages" by statute. 42 U.S.C. 1981a(a)(1). No similar provision can be found within FEHBA. In essence, Saenz is urging this Court to substitute its judg-

[5] Petitioner is apparently referring to the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq.* (as amended by the Civil Rights Act of 1991, 42 U.S.C. 1981a).

ment for that of Congress and to disregard what Congress has intentionally provided within the plain meaning of the statute. Of course, it is not for this Court to determine whether the intention of Congress is logical or beneficial, but rather to interpret the statute consistent with Congress' intent regardless of the desirability of the outcome. *C.I.R. v. Asphalt Products Co., Inc.*, 482 U.S. 117, 121 (1987). The intention of Congress was clear. Unlike the ADA and the Civil Rights Act, FEHBA contains no provision for federal employees to seek extra-contractual damages under the Act. Conversely, Congress determined a preemption provision was necessary to preempt claims arising outside the FEHBA plan.

Saenz further urges that, because an extra-contractual claim may be pursued by a Texas government employee in connection with health benefits under the Texas Employees Uniform Group Insurance Benefit Act, TEX. INS. CODE ANN. § 3.50-2 (West 1981 & Supp. 1996), the FEHBA employee, by analogy, should have a similar right. Pet. 17-18. This argument completely ignores that (1) the Texas system does not have the far reaching control over the employees' benefits which OPM does; (2) a state statute does not need to meet the policy of creating uniformity among different states as the federal statute attempts to do; and (3) most importantly, the state statute does not include a preemption provision. Therefore, this argument is also not persuasive.

Throughout her petition, Saenz attempts to create the impression that, under the interpretation given by the circuit courts directly addressing FEHBA preemption, federal employees have inferior rights to relief compared to those individuals enrolled in group plans in the private sector. The rights and remedies available to a FEHBA participant under a group plan, however, are actually similar to most group plans in the private sector due to the application of ERISA to private sector plans. The Fifth Circuit's decision below is supported by this Court's opinion in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41

(1987), an ERISA case where common law tort and contract claims for benefits under an ERISA-regulated plan were held to be preempted. As noted in *Hayes v. Prudential Life Ins. Co. of America*, "ERISA's preemption clause is similar to § 8902(m)(1) of the FEHBA. [footnote omitted] And the court held that the state claims were preempted despite a savings clause . . . which has no counterpart in the FEHBA." *Hayes*, 819 F.2d at 926. In fact, ultimately, the federal employee arguably ends up with more benefits than an ERISA governed private sector employee because ERISA does not provide the exhaustive regulatory protection that a FEHBA participant receives.

III. FRAUDULENT INDUCEMENT AND BREACH OF FIDUCIARY DUTY CLAIMS ALSO FAIL.

Saenz also seeks reversal as to the fraudulent inducement claim which was held by the Fifth Circuit to be preempted under the authority of *Hayes v. Prudential Ins. Co. of America*, 819 F.2d at 925-26. In further support of preemption of this claim, the Fifth Circuit also cited by analogy, *Hubbard v. Blue Cross and Blue Shield Ass'n.*, 42 F.3d 942, 946-47 (5th Cir.), *cert. denied*, —— U.S. ——, 115 S.Ct. 2276, 132 L.Ed.2d 280 (1995), wherein a fraudulent inducement claim related to an insurer's advertising was held to be preempted under ERISA. Saenz does not even address these cases. Rather, Saenz, in contending the Fifth Circuit erred in finding the fraudulent inducement claim preempted, criticizes the court's reliance on the fact that Humana Health must submit to OPM for prior approval any literature to be distributed at federal facilities to determine if it is in compliance with FEHBA regulations as to misleading, deceptive or unfair advertising. Rec. Vol. 2, pp. 322, 408a & 446. Saenz contends that reviewing material prior to its dissemination does not preclude the possibility of Humana Health not following through with its representations made in a Plan Document. To do so, the petitioner argues, OPM would have to have the ability to perform an audit which, she

claims, "neither FEHBA nor the contract between Humana and OPM make any such provision for that kind of 'audit'." Pet. 24. This is another misstatement of the record by petitioner in that, throughout the contract between OPM and Humana Health, provision was made that OPM had the rights to make audits of the records of Humana Health "as may be necessary to carry out the purpose of the act, regulations and this contract." Rec. Vol. 2, p. 349. Of specific interest is the right of OPM and the General Accounting Office, when conducting audits as required by the FEHBA law, to have access to claims files of federal enrollees and their covered family members. Rec. Vol. 2, p. 359. There is no less than 11 provisions within the agreement between OPM and Humana which allow OPM to audit the files of Humana Health. Therefore, OPM can control the chance of a health plan making a fraudulent representation and, therefore, Saenz's argument on this issue fails.

Regardless, whether claims material can be audited or not is not controlling. As stated in *Hayes v. Prudential Life Ins. Co. of America*, like other extra-contractual claims, permitting a fraud claim would only serve to expand the health plan's obligations and it is, therefore, preempted. *Hayes*, 819 F.2d at 926. The foregoing point raised again by Saenz as to OPM's review of plan material disseminated to government employees, however, demonstrates that a FEHBA participant is not subject to the whim and caprice of the health plan. Congress has empowered OPM to police and protect the participant from precisely the issues raised by Saenz.

The Fifth Circuit did not consider whether a breach of fiduciary duty claim would be preempted as Saenz failed to plead breach of fiduciary duty in the district court. *See Hulsey v. Texas*, 929 F.2d 168, 171 (5th Cir. 1991) (a court of appeals will not consider an issue that was not raised before the district court); *See also Hobbs v. Blackburn*, 752 F.2d 1079, 1083 (5th Cir.), *cert. denied*, 474 U.S. 839 (1985). Therefore, Saenz's urging of reversal

of the fiduciary duty cause of action should not be considered by this Court. Regardless, any such claim has been held to be preempted in the FEHBA context. *See Hayes v. Prudential Life Ins. Co. of America*, 819 F.2d at 926; *Williams v. Blue Cross and Blue Shield of Virginia*, 827 F. Supp. 1228, 1230 (E.D. Va. 1993); *Lieberman v. National Postal Mailhandlers Union*, 819 F. Supp. 344, 348 (S.D.N.Y. 1993); *Bishop v. Continental Ins. Co.*, No. S84-0755 (N.) 1988 U.S. Dist. LEXIS 3244 (S.D. Miss. Jan. 19, 1988).

Additionally, Saenz's reliance upon this Court's ruling in *Varity Corp. v. Howe*, —— U.S. ——, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996) is misplaced. *Varity* involved the application of statutory fiduciary duty obligations created by ERISA. While ERISA and FEHBA are analogous as to the breadth of the "relate to" language of their respective preemption provisions, FEHBA does not contain a breach of fiduciary duty provision such as that found in ERISA. Of course, on the other hand, FEHBA has empowered OPM, as discussed at length before, to exercise authority over the management and administration of government employee health benefits. Under ERISA, no agency has been similarly empowered. Where Congress may have determined there was a need for a statutory fiduciary duty claim in ERISA, it did not find a similar need in FEHBA. In the absence of a statutory provision for such a claim, *Varity* is inapplicable to this FEHBA claim and, for the reasons stated previously, a breach of fiduciary duty claim, if it had been pled, would be preempted.

CONCLUSION

The petition for writ of certiorari should be denied.

Respectfully submitted,

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